

		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0021428</u></p> <p>Facility Name: <u>Walker Nursing Home</u></p> <p>Address: <u>530 East Beardstown St.</u> <u>Virginia</u> <u>62691</u> Number City Zip Code</p> <p>County: <u>Cass</u></p> <p>Telephone Number: <u>(217) 452-3218</u> Fax # <u>(217) 452-7746</u></p> <p>IDPA ID Number: <u>37-0960906</u></p> <p>Date of Initial License for Current Owners: <u>1/1/1955</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Becky Hill</u> Telephone Number: <u>(217) 789-7700</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/1/03</u> to <u>9/30/04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width: 100%;"> <tr> <td style="width: 20%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) <u>George W. White or Mary Ann White</u></td> </tr> <tr> <td></td> <td>(Title) <u>Co-Administrators</u></td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) <u>See Attached Independent Accountant's Report</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Print Name and Title) <u>McGladrey & Pullen, LLP</u></td> </tr> <tr> <td></td> <td>(Firm Name & Address) <u>P.O. Box 159 15 S. Old State Cap. Plaza, Suite 200</u> <u>Springfield, IL 62705</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(217) 789-7700</u> Fax # <u>(217) 753-1654</u></td> </tr> </table> <p style="text-align: center;">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>George W. White or Mary Ann White</u>		(Title) <u>Co-Administrators</u>	Paid Preparer	(Signed) <u>See Attached Independent Accountant's Report</u> (Date) _____		(Print Name and Title) <u>McGladrey & Pullen, LLP</u>		(Firm Name & Address) <u>P.O. Box 159 15 S. Old State Cap. Plaza, Suite 200</u> <u>Springfield, IL 62705</u>		(Telephone) <u>(217) 789-7700</u> Fax # <u>(217) 753-1654</u>
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STATE OF ILLINOIS

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Facility Name & ID Number Walker Nursing Home# 0021428 Report Period Beginning: 10/1/03 Ending: 9/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>71</u>	Skilled (SNF)	<u>71</u>	<u>25,986</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>71</u>	TOTALS	<u>71</u>	<u>25,986</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>366</u>	<u>1,822</u>		<u>2,188</u>	8
9	SNF/PED					9
10	ICF	<u>10,100</u>	<u>7,845</u>		<u>17,945</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,466</u>	<u>9,667</u>		<u>20,133</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 77.48%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒NO ☐

I. On what date did you start providing long term care at this location?

Date started 01/01/1955

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☐NO ☒

If YES, enter number

of beds certified and days of care provided Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 9/30/2004 Fiscal Year: 9/30/2004

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning: 10/1/03

Ending: 9/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	112,463	3,204	4,928	120,595		120,595		120,595			1
2	Food Purchase		144,126		144,126		144,126		144,126			2
3	Housekeeping	38,426	11,495		49,921		49,921		49,921			3
4	Laundry	26,422	319	2,206	28,947		28,947		28,947			4
5	Heat and Other Utilities			63,526	63,526		63,526		63,526			5
6	Maintenance	38,945	17,706	28,031	84,682		84,682		84,682			6
7	Other (specify):*											7
8	TOTAL General Services	216,256	176,850	98,691	491,797		491,797		491,797			8
	B. Health Care and Programs											
9	Medical Director			2,600	2,600		2,600		2,600			9
10	Nursing and Medical Records	694,427	50,555	33,783	778,765		778,765		778,765			10
10a	Therapy			1,325	1,325		1,325		1,325			10a
11	Activities	19,080	5,219		24,299		24,299		24,299			11
12	Social Services	21,271			21,271		21,271		21,271			12
13	Nurse Aide Training											13
14	Program Transportation			2,187	2,187		2,187		2,187			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	734,778	55,774	39,895	830,447		830,447		830,447			16
	C. General Administration											
17	Administrative	92,837			92,837		92,837		92,837			17
18	Directors Fees											18
19	Professional Services			34,269	34,269		34,269		34,269			19
20	Dues, Fees, Subscriptions & Promotions			5,449	5,449		5,449	(1,481)	3,968			20
21	Clerical & General Office Expenses	39,572	25,468	13,202	78,242		78,242		78,242			21
22	Employee Benefits & Payroll Taxes			189,278	189,278		189,278		189,278			22
23	Inservice Training & Education			320	320		320		320			23
24	Travel and Seminar			4,644	4,644		4,644		4,644			24
25	Other Admin. Staff Transportation			12,390	12,390		12,390		12,390			25
26	Insurance-Prop.Liab.Malpractice			51,576	51,576		51,576		51,576			26
27	Other (specify):* See Attached			34,336	34,336		34,336	(34,336)				27
28	TOTAL General Administration	132,409	25,468	345,464	503,341		503,341	(35,817)	467,524			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,083,443	258,092	484,050	1,825,585		1,825,585	(35,817)	1,789,768			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number Walker Nursing Home

#0021428

Report Period Beginning:

10/1/03

Ending:

9/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			30,253	30,253		30,253	46,141	76,394			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			25,508	25,508		25,508		25,508			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			512	512		512		512			35
36	Other (specify):*											36
37	TOTAL Ownership			56,273	56,273		56,273	46,141	102,414			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			496	496		496		496			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,450	40,450		40,450		40,450			42
43	Other (specify):* State Income Tax			1,916	1,916		1,916		1,916			43
44	TOTAL Special Cost Centers			42,862	42,862		42,862		42,862			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,083,443	258,092	583,185	1,924,720		1,924,720	10,324	1,935,044			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning: 10/1/03

Ending: 9/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	46,141	30		9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(1,332)	27		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)	(3,650)	27		16
17 Non-Care Related Fees				17
18 Fines and Penalties	(792)	27		18
19 Entertainment	(23,087)	27		19
20 Contributions	(5,475)	27		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional	(350)	20		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising	(1,131)	20		28
29 Other-Attach Schedule				29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ 10,324		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)			34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ 10,324		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.			\$		38
39					39
40 Gift and Coffee Shops					40
41 Barber and Beauty Shops					41
42 Laboratory and Radiology					42
43 Prescription Drugs					43
44 Exceptional Care Program					44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

Walker Nursing Home

ID# 0021428

Report Period Beginning: 10/1/03

Ending: 9/30/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

9/30/04

9/30/04

[illegible]

Summary B

9/30/04

9/30/04

[illegible]

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning:

10/1/03

Ending:

9/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
George W. White	50%	None				
Mary Ann White	50%	None				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/1/03 Ending: 9/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mary Ann White	President	Co-Adminstrator	50.00	0	50	40.00	Salary	\$ 16,890	17-1	1
2			Office Manager				60.00	Salary	25,336	21-1	2
3											3
4	George W. White	Vice-President	Co-Adminstrator	50.00	0	50	40.00	Salary	19,002	17-1	4
5			Maintenance				60.00	Salary	23,224	1-Jun	5
6											6
7	Bryan White	None	Asst. Admin	0.00	0	40	80.00	Salary	28,953	17-1	7
8			Clerical				20.00	Salary	7,238	21-1	8
9											9
10	Rachel White	None	Asst. Admin.	0.00	0	40	80.00	Salary	27,992	17-1	10
11			Clerical				20.00	Salary	6,998	21-1	11
12											12
13								TOTAL	\$ 155,633		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Walker Nursing Home# 0021428

Report Period Beginning:

10/1/03

Ending:

9/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2	3	4	5	6	7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							\$	\$			\$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	\$			\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$	\$			\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.

\$

None

Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number Walker Nursing Home

0021428 Report Period Beginning: 10/1/03 Ending: 9/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	15,633	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	23,509	2
3. Under or (over) accrual (line 2 minus line 1).			\$	7,876	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	17,632	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	25,508	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1999	19,539	8	
		2000	20,670	9	
		2001	20,511	10	
		2002	20,844	11	
		2003	23,509	12	
		FOR OHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2003	\$	13
		14	PLUS APPEAL COST FROM LINE 5	\$	14
		15	LESS REFUND FROM LINE 6	\$	15
		16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Walker Nursing Home COUNTY Cass

FACILITY IDPH LICENSE NUMBER 0021428

CONTACT PERSON REGARDING THIS REPORT Becky Hill

TELEPHONE (217) 789-7700 FAX #: (217) 753-1654

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-033-009-00</u>	<u>Lot</u>	\$ <u>861.34</u>	\$ <u>861.34</u>
2. <u>11-087-007-00</u>	<u>Lot</u>	\$ <u>18,842.14</u>	\$ <u>18,842.14</u>
3. <u>11-052-009-00</u>	<u>Lot</u>	\$ <u>631.82</u>	\$ <u>631.82</u>
4. <u>11-076-003-00</u>	<u>Lot</u>	\$ <u>1,692.06</u>	\$ <u>1,692.06</u>
5. <u>11-064-010-01</u>	<u>Lot</u>	\$ <u>1,481.72</u>	\$ <u>1,481.72</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>23,509.08</u></u>	\$ <u><u>23,509.08</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

A. Square Feet: 23,040

B. General Construction Type:
 Exterior Brick
 Frame Wood and Steel
 Number of Stories 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).
 None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO
 If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home	22,176	1955	\$ 11,000	1
2	Nursing Home	9,504	1981	23,604	2
3	TOTALS	31,680		\$ 34,604	3

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning:

10/1/03

Ending:

9/30/04

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	20		1972	1972	\$ 130,523	\$	30	\$		\$ 130,523	4
5	30		1977	1977	363,607		30	12,120	12,120	327,240	5
6	5		1981	1981	79,226		30	2,641	2,641	62,674	6
7	16		1985	1985	399,762	86	30	13,326	13,240	253,194	7
8											8
9	Improvement Type**										
10	Building Improvements										
11			1974		900					900	10
12			1975		200					200	11
13			1977		2,889		Various	23	23	2,821	12
14			1982		552		Various			552	13
15			1983		533		Various			533	14
16			1984		11,510		Various	184	184	11,510	15
17			1985		70,113		Various	736	736	69,394	16
18			1986		7,764	404	Various	204	(200)	5,509	17
19			1988		2,015	64	Various	66	2	1,073	18
20			1990		2,480		Various	165	165	2,434	19
21			1991		23,204	684	Various	817	133	10,192	20
22			1992		45,807	1,455	Various	1,502	47	19,266	21
23			1993		11,951	364	Various	374	10	4,175	22
24			1995		4,939	304	Various	432	128	4,078	23
25			1996		6,289		Various	613	613	5,332	24
26			1997		63,654	2,132	Various	2,132		15,502	25
27			1998		45,605	1,169	Various	1,144	(25)	6,933	26
28			1999		2,066	53	Various	53		236	27
29			2000		4,528	113	10	453	340	1,358	28
30	Detail Improvements for the years 2001-2004										
31	Shower Faucets		2001		1,550	39	10	155	116	466	31
32	Door locks		2002		1,500	150	10	150		450	32
33	Water Heater		2003		4,283	107	10	428	321	785	33
34	New Roof		2004		28,437	118	10	355	237	355	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,315,887	\$ 7,242		\$ 38,073	\$ 30,831	\$ 937,685	70

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 638,334	\$ 10,208	\$ 23,892	\$ 13,684	3-39 yrs	\$ 567,539	71
72	Current Year Purchases	62,185	2,031	3,183	1,152	5-10 yrs	3,183	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 700,519	\$ 12,239	\$ 27,075	\$ 14,836		\$ 570,722	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	Handicap Bus	2002	\$ 44,980	\$ 8,998	\$ 11,246	\$ 2,248	4	\$ 27,915	76
77										77
78										78
79										79
80	TOTALS			\$ 44,980	\$ 8,998	\$ 11,246	\$ 2,248		\$ 27,915	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,095,990	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 28,479	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 76,394	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 47,915	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,536,322	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1996 Dodge Ram	\$ 33,608	\$ 1,775	\$ 21,560	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 33,608	\$ 1,775	\$ 21,560	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2005 \$ _____

13. /2006 \$ _____

14. /2007 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					1	Licensed Occupational Therapist		hrs	\$	
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		25	1,325		25	1,325	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	25	\$ 1,325	\$	25	\$ 1,325	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning: 10/1/03

Ending:

9/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/04

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 56,754	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	110,350		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	431,463		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Loans to Officers</u>	33,927		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 632,494	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,924		12
13	Land	34,604		13
14	Buildings, at Historical Cost	1,311,603		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	783,392		16
17	Accumulated Depreciation (book methods)	(1,752,734)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Income Tax Deposit</u>	14,643		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 393,432	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,025,926	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 18,989	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	33,783		30
31	Accrued Taxes Payable (excluding real estate taxes)	359		31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,632		32
33	Accrued Interest Payable	1,377		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 72,140	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 72,140	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 953,786	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,025,926	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 925,986	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 925,986	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	129,074	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(101,274)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 27,800	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 953,786	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,043,762	1
2	Discounts and Allowances for all Levels	(14,587)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,029,175	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	23,218	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 23,218	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,401	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,401	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,053,794	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	491,797	31
32	Health Care	830,447	32
33	General Administration	503,341	33
	B. Capital Expense		
34	Ownership	56,273	34
	C. Ancillary Expense		
35	Special Cost Centers	496	35
36	Provider Participation Fee	40,450	36
	D. Other Expenses (specify):		
37	State Income Taxes	1,916	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,924,720	40
41	Income before Income Taxes (line 30 minus line 40)**	129,074	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 129,074	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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Facility Name & ID Number Walker Nursing Home

0021428

Report Period Beginning: 10/1/03

Ending:

9/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,291	2,301	\$ 58,580	\$ 25.46	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,271	2,267	43,489	19.18	3
4	Licensed Practical Nurses	15,490	15,522	252,410	16.26	4
5	Nurse Aides & Orderlies	37,177	37,393	339,948	9.09	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,618	1,629	14,270	8.76	9
10	Activity Assistants	730	734	4,810	6.55	10
11	Social Service Workers	1,809	1,817	21,271	11.71	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,362	3,375	31,147	9.23	14
15	Cook Helpers/Assistants	10,809	10,870	81,316	7.48	15
16	Dishwashers					16
17	Maintenance Workers	2,796	2,756	38,945	14.13	17
18	Housekeepers	5,583	5,608	38,426	6.85	18
19	Laundry	3,227	3,242	26,422	8.15	19
20	Administrator	2,080	2,015	35,892	17.81	20
21	Assistant Administrator	3,200	3,218	56,945	17.70	21
22	Other Administrative					22
23	Office Manager	1,040	994	25,336	25.49	23
24	Clerical	960	965	14,236	14.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	94,443	94,706	\$ 1,083,443 *	\$ 11.44	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	176	\$ 4,928	1-3	35
36	Medical Director	26	2,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	25	1,325	10A-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	227	\$ 8,853		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	1,429	27,406	10-3	52
53	TOTAL (lines 50 - 52)	1,429	\$ 27,406		53

Facility Name & ID Number Walker Nursing Home

0021428

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount				
George W. White	Co-Administrator	50	\$ 19,002	Workers' Compensation Insurance	\$ 39,583	IDPH License Fee	\$ 287				
Mary Ann White	Co-Administrator	50	16,890	Unemployment Compensation Insurance	8,986	Advertising: Employee Recruitment	1,380				
Bryan White	Asst. Administrator	0	28,953	FICA Taxes	81,186	Health Care Worker Background Check (Indicate # of checks performed <u>25</u>)	312				
Rachel White	Asst. Administrator	0	27,992	Employee Health Insurance	59,480	Advertising	1,481				
				Employee Meals		Credits	(1,296)				
				Illinois Municipal Retirement Fund (IMRF)*		Dues	1,207				
				Other	43	Other	1,297				
						Subscriptions	781				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 92,837		Less: Public Relations Expense	(350)				
B. Administrative - Other						Non-allowable advertising					
Description			Amount			Yellow page advertising	(1,131)				
			\$								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$		TOTAL (agree to Sch. V, line 20, col. 8)	\$ 3,968				
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount			
See attached schedule			\$ 34,271				Out-of-State Travel	\$			
							In-State Travel				
							Lodging	509			
							Seminar Expense	3,895			
							Activity Director Training	240			
							Entertainment Expense	(
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				\$ 34,271	TOTAL	\$	(agree to Sch. V, line 24, col. 8)	\$ 4,644			

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

[illegible]

Facility Name & ID Number Walker Nursing Home

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Report Period Beginning:

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount. INHAA \$200
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 9.7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,823 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 40,450
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes-pg 7 If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.